MEMORANDUM

TO:      Anne Hadreas, Rebecca Cervenak
FROM:    Jeanette Hawn
RE:      Positive Features of Community-Based Competency Restoration Programs Outside CA
DATE:    July 21, 2016

In preparation for a meeting of the IST Workgroup on July 22, 2016, a brief review of a few community-based competency restoration programs (also referred to as outpatient competency restoration programs) in other states has been conducted to identify features that a California community-based competency restoration program may include. According to a 2015 article in the World Journal of Psychiatry, 35 states have specific statutes allowing for outpatient community restoration but only 16 states have functioning programs. Nicole R. Johnson, et al., Outpatient Competence Restoration: A Model and Outcomes, 5 WORLD J. PSYCHIATRY 2 (July 22, 2015), at 229, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4473494/pdf/WJP-5-228.pdf. Wisconsin’s program restored 75% of the 121 individuals served in the period studied (2012-2013), making it one of the most successful programs in the nation. Id. More states are adopting and expanding such programs because they provide treatment in less restrictive environments and are less costly than inpatient programs. Id. at 230.
Specific information about how these programs are run is not readily available on the internet but there appear to be more detailed reviews of these programs in private forensic psychiatry and psychology journals that may aid with future research on this subject. A brief summary of some positive features of these community-based competency restoration programs can be found below followed by notes regarding the characteristics of the programs reviewed.

I. Summary of Positive Features of Community-Based Competency Restoration Programs

1. Starting point is placement in the community for restoration to competency, unless the court specifically finds inpatient hospital treatment is required
2. Step-down to less restrictive placement in community
3. Utilization of local specialized mental health service providers with oversight and funding provided by the appropriate state mental health agency
4. Dedicated entity to monitor compliance with contract requirements, laws, and regulations
5. Specialized and highly trained/experienced professionals on staff
   a. Director/Commissioner of overseeing agency, pursuant to statute, approves the training and qualifications of professionals involved in the evaluation and treatment of committed individuals
   b. “Boundary Spanner” – staff that bridges MH, criminal justice, and substance abuse systems and manages cross-system staff interactions
   c. Cross-trainer case managers – with adequate knowledge and experience in mental health and criminal justice systems
   d. “Peer-specialists” to provide peer support
6. Doctor (preferably psychiatrist) and/or committing judge meets with and/or reviews the individual’s status every 3 months and 30 days before expiration of commitment period
7. Ability to arrange competency evaluation and notify court of restoration of competency, or determination that an individual is likely to remain incompetence for the foreseeable future, at any time after the initiation of restoration services
8. Review of treatment plan by committee comprised of representatives from the overseeing agency, mental health service provider, competency restoration program, state attorney’s office
9. Coordination between competency restoration program and jail or court to ensure daytime release of individual and/or “warm hand-off”
   a. Provide care within 24 hours of release from jail or court. Provide access to a physician, preferably a psychiatrist, no later than 7 working days after release
   b. Provide prompt access to legal education using approved curricula based on individual needs

10. Thorough screening process to identify (1) Mental illness; (2) Social issues; (2) substance abuse issues; (3) risk of violence to self or others

11. Individualized treatment plan based on individual’s deficiencies and provision of comprehensive services necessary to stabilize the individual and maximize their success including: access to medications, housing, transportation, structured activities, Social Security, Medicaid, counseling, work rehabilitation, support groups, substance abuse treatment
   a. Face-to-face services multiple times per week
   b. More frequent and shorter meetings if necessary due to individual’s needs

12. Uniform manual for assessments and guidance in treatment

13. Regular assessments and reporting:
   a. Primary restoration contact completes weekly progress records and notes continuing problem areas and completes monthly progress records and project training goals for next three months (or less frequently for certain charges)
   b. Regular reports to committing court

14. Discharge planning to ensure continuity of care including a plan to: (1) maintain housing and utilities for at least three months post discharge; (2) facilitate ongoing services in the appropriate local service provider; (3) provide medication and follow-up psychiatrist appointment to ensure no lapse in medication compliance after discharge; (4) complete all appropriate benefits applications, including signing up for long-term subsidized housing

15. For those not restored or determined to be incapable of restoration, the competency restoration program works closely with the court to encourage timely resolution of legal issues and minimize jail time spent waiting for hearing
Notes Regarding the Programs Reviewed:

I. PROGRAMS REVIEWED:
   a. Florida – Florida’s community-based competency restoration programs are truly community-based. The provision of services is decentralized and services are contracted for within each judicial circuit. These programs include: Florida Partners in Crisis (FLPIC) (Circuits 9 & 18) and Miami-Dade Forensic Alternative Center (MD-FAC) (Circuit 11)
   b. Wisconsin – Outpatient Competency Restoration Program (OCRP)
   c. Virginia – Similar to Florida, local Community Services Boards and Behavioral Health Authorities administer services in their communities
   d. Texas – NorthSTAR

II. OVERSIGHT
   e. FLPIC – Forensic Screening Committee (FSC) made up of representatives from the Northeast Florida State Hospital Care Coordination Department, DCF Substance Abuse and Mental Health Program Office, and Lakeside Behavioral Health Care; Each circuit has a Forensic Specialist
   f. OCRP - Department of Health Services contracts with Behavioral Health Consultants to manage the program but DHS ultimately oversees the program
      i. Doctor and/or judge meets with the individual every three months and 30 days before expiration of commitment according to statute
   g. Virginia - VA Dept of Behavioral Health and Developmental Services (DBHDS) oversees (and provides a manual for guidance) Community Services Boards and Behavioral Health Authorities
      i. Commissioner of Behavioral Health and Developmental Services approves the training and qualifications of individuals authorized to conduct evaluations and provide restoration services pursuant to statute
   h. Texas – contracts with private provider NorthSTAR pursuant to service contract
III. REFERRAL PROCESS

i. FLPIC

i. Once found incompetent to proceed: (1) Referral to program is completed by defense counsel or community MHP; (2) The forensic/community restoration specialist at Lakeside Behavioral Health Care reviews the information and meets the individual for assessment; (3) The specialist’s findings and the referral information are reviewed by the FSC to determine if the individual meets program criteria (reviews every two weeks or more often if necessary, referral source is invited to attend)

j. MD-FAC

i. Once found incompetent to proceed: (1) Mental Health Administrative Office of the Courts (MHAOC) makes referral to Forensic Team (Judge, MH staff from DCF, Bayview, and state attorney’s office); (2) Forensic Team assesses the individual and determines whether admittance to the program is appropriate based on eligibility criteria; (3) MD-FAC staff screen the referred person and submit written disposition to MHAOC; (4) Presiding judge is informed of eligibility; (5) Court commits the individual to DCF; (6) Court orders Dept of Corrections to transport the individual to MD-FAC; (7) South Florida Behavioral Health Network (SFBHN) monitors and coordinates admission and provides ongoing monitoring to ensure compliance, provides program technical assistance to ensure compliance with contract requirements and applicable laws and regs, acts as liaison to program

k. OCRP

i. Recommendations for program can be suggested in the competency examiner’s report or by the court by completing an Order of Commitment form noting referral to program

ii. (1) Behavioral Health Consultants’ review the file (2) a licensed psychologists screens the referred individual (not clear what criteria used) and (3) an environmental assessment is conducted by case management personnel in the individual’s residence to ensure general safety and stability of the residence, gather information on community providers and the support system, and review program
expectations and rules related to conduct outside the treatment sessions

iii. Clinical Director reviews and determines whether OCRP is appropriate

IV. ELIGIBILITY CRITERIA

I. FLPIC:
   i. Adult
   ii. Major Axis I diagnosis – usually schizophrenia, bipolar disorder, schizo-affective disorder
   iii. Felony charge (most second or third degree felonies)
   iv. Willing to participate in weekly training sessions
   v. Excluded: (1) Complex medical conditions (i.e. closed head injuries, dementia); (2) Moderate to severe mental retardation; (3) Extensive violent criminal history

m. MD-FAC:
   i. At least 18 years of age
   ii. Charged with felony in 11\textsuperscript{th} Judicial Circuit Court
   iii. Free of major medical conditions or shall have controlled stable medical conditions as determined by the Southern Region’s Medical Exclusionary Guidelines for Crisis Stabilization Units and Stand Alone Receiving Facilities for CSU 2009
   iv. Individuals must be continent, ambulatory, or capable of self-transfer
   v. Acutely mentally ill and in need of intensive staff supervision, support and assistance as documented in a psychiatric or psychological evaluation
   vi. Excluded: previously convicted of, found incompetent to proceed on, found NGI, or currently charged with homicide, domestic battery by strangulation, kidnapping, sexual battery, lewd or lascivious battery/molestation, arson (including fire bombs or explosives), home invasion robbery, aggravated child abuse, aggravated elder abuse, aggravated abuse of a person with a disability, aggravated stalking

V. PROGRESS THROUGH THE PROGRAM

n. MD-FAC: (1) Initial placement in locked inpatient setting to receive crisis stabilization, short-term residential treatment, competency restoration services; (2) Step-down to less restrictive placement in
community (assisted with re-entry and ongoing services); (3) Once competency restored, program prepares treatment summary and recommendation for community placement; (4) Committing court holds hearing to review recommendations and appropriateness of recommendations; (5) If court approves community placement, MD-FAC staff provide assistance with re-entry and monitors individuals

o. Virginia – (1) restoration to competency treatment is provided in the community unless the court finds inpatient hospital treatment is required (Code of Virginia § 19.2-169.2)
   i. At any point after initiation of restoration services, the restoration provider believes the individual (1) has been restored to competence or (2) is likely to remain incompetent for the foreseeable future, the restoration trainer should notify the treating organization’s director so that a follow-up competency evaluation can be arranged

p. Texas – Ensure daytime release to NorthSTAR provider and avoid nighttime release of IST individuals

VI. INTEGRATED AND COMPREHENSIVE SERVICES

q. FLPIC – Funded by the Department of Children and Families (DCF), community mental health providers provide mental health treatment services
   i. Types: All necessary to stabilize symptoms and maximize success including medications, housing, Social Security, Medicaid, counseling, work rehab, support groups, substance abuse treatment

r. MD-FAC Specially Trained Staff
   i. “Boundary Spanner” – staff that bridges MH, criminal justice, and substance abuse systems and manages cross-system staff interactions
   ii. Cross-trainer case managers – with adequate knowledge and experience in mental health and criminal justice systems
   iii. Participants are linked with supportive housing
   iv. “Peer-specialists” to provide peer support
   v. Individual plan of active treatment containing clinical evidence of therapeutic goals to be met before the individual can be moved to a less-restrictive level of care
   vi. Integrated dual-diagnosis treatment
vii. Assistance securing employment
viii. Cognitive Behavioral Interventions – targeting risk factors for recidivism
s. OCRP – Treatment team consists of Supervisors, Clinical Program Director, Behavioral Specialist, and Case Manager
   i. Total of approximately four individual treatment session per week
   ii. Behavioral Specialists sessions 2/week for one hour sessions
   iii. Case Management 1/week in the home
   iv. Regular reports to the court
t. Virginia
   i. Uniform initial assessment form and uniform restoration training components to be presented to individual (i.e. purposes of restoration training, legal rights, review of charges/consequences/evidence, pleas, court system, defense attorney, etc)
   ii. Uniform materials to assess competency restoration
   iii. Treatment tailored to specific deficits of individual
      1. Restoration plan based on individual’s factual understanding and rational understanding of legal issues and proceedings, ability to communicate, source of deficits (cognitive, symptoms of mental illness, impaired attention or concentration, affective issues, motivation issues)
         a. Restoration sessions; psychiatric evaluations; supportive counseling; medication monitoring; encourage involvement in structured activities; refer to case management for housing, transportation, benefits, etc.; individual/group psychotherapy;
      2. Restoration sessions at least once per week 45-60 minutes
         a. More frequent and shorter sessions as necessary (i.e. for individuals with cognitive impairments)
   iv. Restoration trainer to complete weekly progress records and note continuing problem areas
v. Restoration trainer to complete monthly progress records and project training goals for next three months (or less frequently for certain charges)

vi. Restoration trainer to provide organization’s director with status update 30 days before expiration of commitment

vii. VA Dept of Behavioral Health and Developmental Services Forensic Office staff and forensic coordinators at state hospital are available for consultation with treating organization staff

u. Texas
   i. Comprehensive screening in addition to eligibility and intake assessments – (1) Psychosocial assessment, (2) substance abuse screening, (3) risk assessment
   ii. Provide referral and access to substance abuse treatment within 21 days of identifying a substance abuse issue
   iii. Treatment plan shall address: (1) Physical health concerns/issues; (2) Medication and medication management; (3) Family and community support; (4) Co-occurring psychiatric and substance use disorder concerns or issues; (5) supported housing, including rental/utility subsidy; (6) transportation; and (7) assistance with benefits applications
   iv. Provide care within 24 hours of release from jail or court. Provide access to a physician, preferably a psychiatrist, no later than 7 working days after release.
   v. Provide prompt access to legal education using approved curricula based on individual needs
   vi. Face-to-face services at least twice weekly
   vii. Provide report to court no later than the 15th day before the date on which the commitment is to expire
   viii. Promptly notify the court when the provider believes the individual has attained competency or is not likely to attain competency in the foreseeable future
   ix. **Discharge planning to ensure continuity of care** – (1) discharge planning shall ensure there is a plan for maintaining housing and utilities for at least three months post discharge; (2) facilitate ongoing services in the appropriate local service provider; (3) provide medication and follow-up psychiatrist appointment to ensure no lapse in medication compliance after discharge; (4) complete all
appropriate benefits applications, including signing up for long-term subsidized housing; (5) For those not restored or determined to be incapable of restoration, work closely with the court to encourage timely resolution of legal issues and minimize jail time spent waiting for hearing